

## DOCUMENT RESUME

ED 234 458

CS 504 393

AUTHOR Redland, Alice R.  
TITLE An Investigation of Nurses' Interaction Styles with Physicians and Suggested Patient Care Interventions.  
PUB DATE May 83  
NOTE 27p.; Paper presented at the Annual Meeting of the International Communication Association (Dallas, TX, May 26-30, 1983).  
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)  
EDRS PRICE MF01/PC02 Plus Postage.  
DESCRIPTORS Assertiveness; \*Communication Research; \*Interaction; \*Interaction Process Analysis; \*Interpersonal Communication; Medical Care Evaluation; Medical Services; \*Nurses; \*Physicians

## ABSTRACT

The purpose of this study was to identify relations between nurses' interaction styles and patient care interventions (PCI) that occurred after nurse-doctor interactions. A nonparticipant observer recorded interactions of 48 female registered nurses with physicians. Transcripts were coded and assigned to one of five theoretical nurse interaction style categories: avoidance, competition, accommodation, collaboration, and compromise. Inspection of 239 interactions of a subsample of 38 nurses revealed a difference by basic education of the nurse. When the nurses did not suggest PCI, a collaborative style was used most frequently by both diploma (62% of the time) and baccalaureate (70%) graduates. When PCI was suggested, diploma graduates used an accommodative style most (72% of the time), and baccalaureate graduates used a collaborative style most (50%). Medications were the most frequently suggested PCI by both diploma and baccalaureate graduates. The differential findings for the diploma and baccalaureate graduates may be the result of socialization experiences in nursing school and a trend toward a knowledge-oriented (as opposed to a rule-oriented) nursing practice. (Author)

\*\*\*\*\*  
\* Reproductions supplied by EDRS are the best that can be made \*  
\* from the original document. \*  
\*\*\*\*\*

ED234458

U.S. DEPARTMENT OF EDUCATION  
NATIONAL INSTITUTE OF EDUCATION  
EDUCATIONAL RESOURCES INFORMATION  
CENTER (ERIC)

X This document has been reproduced as  
received from the person or organization  
originating it.

☐ Minor changes have been made to improve  
reproduction quality.

• Points of view or opinions stated in this docu-  
ment do not necessarily represent official NIE  
position or policy.

AN INVESTIGATION OF NURSES' INTERACTION STYLES WITH PHYSICIANS  
AND SUGGESTED PATIENT CARE INTERVENTIONS

"PERMISSION TO REPRODUCE THIS  
MATERIAL HAS BEEN GRANTED BY

Alice R. Redland

TO THE EDUCATIONAL RESOURCES  
INFORMATION CENTER (ERIC)."

Alice R. Redland  
The University of Texas at Austin  
School of Nursing  
1700 Red River  
Austin, Texas 78701  
(512) 471-7311

Health Communication Division  
International Communication Association  
33rd Annual Conference  
Dallas, Texas  
May 26-30, 1983

CS 504393

AN INVESTIGATION OF NURSES' INTERACTION STYLES WITH PHYSICIANS

AND SUGGESTED PATIENT CARE INTERVENTIONS

(ABSTRACT)

The purpose of this study was to identify relations between nurses' interaction styles and patient care interventions (PCI) that occurred after nurse-doctor interactions. A nonparticipant observer recorded interactions of 48 female registered nurses with physicians. Transcripts were coded and assigned to one of five theoretical nurse interaction style categories. Inspection of 239 interactions of a subsample of 38 nurses revealed a difference by basic education of the nurse. When the nurses did not suggest PCI, a collaborative style was used most frequently by both diploma (62% of the time) and baccalaureate (70%) graduates. When PCI were suggested, diploma graduates used an accommodative style most (72% of the time), and baccalaureate graduates used a collaborative style most (50%). Medications were the most frequently suggested PCI by both diploma and baccalaureate graduates. The differential findings for the diploma and baccalaureate graduates may be the result of socialization experiences in nursing school and a trend toward a knowledge-oriented (as opposed to a rule-oriented) nursing practice.

## AN INVESTIGATION OF NURSES' INTERACTION STYLES WITH PHYSICIANS AND SUGGESTED PATIENT CARE INTERVENTIONS

Communication or information exchange about patient care between nurses and physicians is necessary so they can be in concert when working with a specific patient. More information is needed about present systems of nurse-physician interaction and their effects on medical and nursing practice and on health care. How physicians and nurses manage their common concerns for patient care and how their interactions affect decisions about patient care must be explored. Of interest in this study were the interaction styles nurses use when interacting with physicians about patient care.

### PURPOSE

The purpose of this study was to examine interactions about patient care between registered nurses and medical doctors, with the view to identifying the relation between the nurses' interaction styles and patient care interventions (PCI) that occurred after the nurse-doctor interactions. Specific questions addressed included:

1. What interaction styles do nurses use when they interact with doctors?
2. When nurses suggest PCI to physicians, what interaction styles do they use?
3. Do nurses with different educational backgrounds use different interaction styles?

### BACKGROUND FOR THE STUDY

#### Communication, A Factor In Nurse-Physician Relationships

A significant factor in quality of care is effective communication among members of the health care team, especially nurses and physicians (Duff & Hollingshead, 1968). Information exchange about patient care is often minimal.

Frequently, physicians visit their patients in the hospital without exchanging information with nursing staff members. Patients' records become the primary mode of communication. Most often, messages from physicians to nurses are in the form of written orders for implementation of medical treatment plans. One nurse has characterized this tendency toward voluntary isolation as being much like the parallel play of young children. Each is aware of the other, but each chooses not to interact if at all possible (Taylor, 1970). This pattern constitutes an avoidance strategy, which minimizes interpersonal exchange.

Nurses and physicians frequently have differing expectations of the other, a factor which affects their relationship and creates the potential for conflict. When a nurse and physician do interact, the physician is often seen by the nurse as quite directive and lacking in behaviors that encourage the participation of the nurse (Bates & Chamberlin, 1970). Consequently, the nurse does not share pertinent information with the physician unless it is requested. Likewise, the physician does not share information, primarily because its usefulness for the patient's nursing care plan is not considered (Taylor, 1970).

#### Doctor-Nurse Games

The use of games in health care situations, Levin and Berne (1972) speculate, is a consequence of the belief that a patient's care must be under the control and direction of only one person, usually the physician. Stein (1967) notes that the "attitudes underlying the game are serious obstacles in the path of meaningful communication between physicians and nonmedical professional groups" (p. 699).

Rushing (1965) sheds light on the nuances of the doctor-nurse relationship. Nurses have two strong guiding moral principles that shape their actions. One is a commitment to patient concerns---to help patients recover

from or adapt to illnesses. The second commitment is to carry out doctors' orders, that is, to be subordinate to their responsibility. When nurses believe that the execution of these two principles are in conflict, as when a treatment is believed detrimental, they must determine a course of action to resolve the conflict. A small number simply conform to the physician's authority. Some nurses learned that inverting the status differences by direct questioning or challenge of physician's orders can create strain and overt conflict (Rushing, 1965).

Other nurses use several strategies to influence the physician. Recommendations (typically, to alter some portion of the patient's treatment plan) are made in such a way as to appear to have not done so. One means of conflict management is to avoid stating a position or belief directly; instead, questions about medical orders are asked as if they are not understood. A common strategy for nurses is to report observations about a patient without stating their own opinions. A nurse's presentation of data indicates a recommended treatment plan (Rushing, 1965) and represents an accommodative form of interaction.

#### Conflict Management Behaviors

Thomas (1976) suggests that how a person behaves within the context of conflict depends on tendencies developed from personality traits, motives, and abilities. How individuals conceptualize the conflict situation and the meaning it holds for them influences their behavior, predisposing them to behave in certain somewhat predictable ways. No person has a totally inflexible, predetermined course of action; however, a particular mode of behavior could be favored over others.

Thomas' (1976) conception of conflict management behaviors is based on the normative work of Blake and Mouton (1964). Others (Hall, 1969; Jamieson &

Thomas, 1974; Lawrence & Lorsch, 1967) use similar constructs and identify two dimensions for conflict management behaviors: concern for relationships or others and concern for self or personal goals. Empirical evidence of the two-dimensional approach to conflict management behavior is reported by Ruble and Thomas (1976). Combinations of the extremes of the two dimensions and an intermediate position among these four extremes result in five theoretically different conflict management styles. They are identified here as avoidance, competition, accommodation, collaboration, and compromise.

Avoidance is characterized by a belief that negotiation about problems is hopeless and useless. A low concern for self and for relationships or other persons is manifested in physical or mental withdrawal from situations that could be subject to disagreement. Compliance to prevent disagreements is not uncommon, and there is little commitment to decisions that are made. A person who uses avoidance is non-assertive and passive, failing to take a position on issues. Cooperation from others is not actively sought. Refusal to engage in open conflict is evidenced in sidestepping and withdrawal from open discussion of problems (Blake & Mouton, 1964; Blake & Mouton, 1978; Hall, 1969; Jamieson & Thomas, 1974; Thomas, 1976).

Competition is characterized by a belief that what is right will prevail and that the position one takes is important above all else. A high concern for self and a low concern for relationships with others is evident in the view that interactions are win or lose transactions. Competitive persons push their own concerns at the expense of other persons. Aggressive behaviors are exhibited, and facts and authorities are quoted to support the contention that the other person is wrong. Evaluative and dogmatic terms are frequently used (Blake and Mouton, 1964; Blake & Mouton, 1978; Hall, 1969; Jamieson & Thomas, 1974; Lawrence & Lorsch, 1967; Thomas, 1976).

Accommodation is characterized by a belief that interpersonal relationships are more important than disagreements. A low concern for one's own goals and a high concern for acceptance by others are reflected in a preference for harmonious relations. The person who accommodates is non-assertive and cooperative, yielding to the desires of the other. Humor is used to break tension or move discussion to a neutral topic (Hall, 1969; Jamieson & Thomas, 1974; Lawrence & Lorsch, 1967; Thomas, 1976). Opinions are expressed in indirect ways. When unavoidable differences do arise, apologies are usual. Information given may be limited to what will make the situation least objectionable to the other (Blake & Mouton, 1964; Blake & Mouton, 1978).

Collaboration is characterized by a belief that differences are inevitable but surmountable through objective problem solving. A high concern for self and for relationships with others is manifested in the view that all persons have legitimate contributions to make and the notion that no one is a loser in the transaction. New approaches that maximize the goals of both are identified. Interest in a shared solution provides a common ground for agreement. Trust is evident in the disclosure of one's own goals and concerns. Feelings are expressed with candor and are treated as legitimate factors in negotiation. Rationale for actions as well as objective facts are freely provided (Blake & Mouton, 1964; Blake & Mouton, 1978; Hall, 1969; Jamieson & Thomas, 1974; Lawrence & Lorsch, 1967; Thomas, 1976).

Compromise is characterized by the belief that differences should be treated and resolved in light of the common good. A person who compromises assumes an intermediate position among the four styles described above. Aggression or cooperation are not present. Instead, a midpoint is assumed that does not address the issue; however, that position is not firmly held. Compromise is exemplified by "give a little, take a little" and may become

habitual, serving as a goal in itself. The difference may be split by compromising on each issue or by "averaging" of agreements over time when tradeoffs on issues are made (Blake & Mouton, 1964; Blake & Mouton, 1978; Hall, 1969; Jamieson & Thomas, 1974; Thomas, 1976).

The elements of conflict exist in any relationship. The nurse-physician relationship presents a unique situation in which the nurse's expression of conflict behaviors during interactions with physicians is role-related, if not role-prescribed. Consequently, nurses communicate in a characteristic manner, or style, when discussing patient care with physicians.

#### METHOD

A brief pilot study was conducted in the same community in which the research project was undertaken. Twenty-four interactions of three nurses with ten physicians were recorded, inspected, and coded into interaction style categories. Although the majority of the interactions could be categorized easily, further analysis of some interactions resulted in additions to the coding guide.

#### Subjects

A sample of 52 consenting nurses was recruited from seven general care units of a 455 bed private hospital. Nurses from speciality units were excluded. Four subjects were lost by attrition. Of the 48 remaining nurses, 38 had not undertaken any education beyond their basic nursing preparation. Of these, 12 had diplomas, and 26 had BSN degrees. Data from these 38 nurses are reported here. Each nurse signed an informed consent form prior to participation in the study.

#### Data Collection

The observational data were collected by the investigator between 6:45 and 10:30 A.M. over 121 days, with approximately 400 hours of observation time

coded. Interactions between nurses and physicians were observed as the nurses went about their usual work activities. The majority of the interactions were witnessed at a central desk and in the hallway outside patients' rooms.

The observer wore a white lab coat in order to blend in with the hospital environment. The observation and recording were done as unobtrusively as possible. One initial strategy the observer used to decrease any sense of discomfort the nurse may have had from being observed was to a truthful verbal statement to the nurse, such as "You have a lot of difficult patients here."

When physicians or other persons questioned the observer's presence and purpose, a neutral, noninformative reply was given. When a physician was especially inquisitive or appeared to be ill at ease, he was simply told that the observer was doing a study on nurses. Four physicians who appeared especially uncomfortable when the observer was near were avoided by the observer after that time, and no interactions between that physician and the study nurses were recorded.

The physical arrangement of the patient care units permitted the observer to be near enough to a nurse and doctor to hear their conversation about a patient's condition without obviously listening. At other times, the interactions were carried on in voices loud enough to be heard by many people in the hallway. Not infrequently, the observer's presence was so well accepted that the observer could stand beside the nurse as she talked with the physician. As soon as a nearby study nurse and physician began an interaction, it was given a number and as much verbatim data as possible were hand recorded. Eight interactions per nurse were observed and recorded. No further observations were made when a nurse had had sufficient opportunity to interact with physicians and did not have eight interactions recorded after four observation periods.

Coding of Interaction Data

Each interaction was coded and assigned to one of the five interaction styles identified on the Interaction Coding Guide (Figure 1). This assignment was made according to which category of behavioral descriptors had the greatest frequency of items identified for that individual interaction. When an equal proportion of descriptors was identified in all categories, the interaction was designated as compromising.

\*\*\*\*\*  
Place Figure 1 About Here  
\*\*\*\*\*

The actual coding of the nurses' interactions required the identification of behavioral units within each nurse's statements and the assignment of meanings to these behavioral units. The meaning of the behavioral unit was determined from the function of that unit in the interaction. Process, not content, meaning was determined.

A behavioral unit could be a word, phrase, sentence, or several sentences together which functioned in the interaction to convey a particular meaning. In some cases, a word or a phrase connoting one function was embedded within a phrase or a sentence connoting a different function. Conversational regulators were excluded from the coding. As the functions of the behavioral units were determined, they were labeled as the behavioral descriptors specified in the Interaction Coding Guide. A set of coding definitions and examples were used as guides during this process.

When there was an equal number of behavioral descriptors in two categories of a given interaction, tie-breaking was necessary. The central purpose of the interaction from the nurse's perspective was identified and assigned the style that was more consistent with achieving that purpose. For example, four of the behavioral descriptors might be collaborative and four accommodative in an interaction in which the purpose was to obtain a pain

medication for the patient. If this purpose was shown directly ("Mrs. A. needs a pain medication."), and the accommodative descriptors were not directly related to that purpose ("Hello," "Goodbye," and "Thank you"), the interaction was designated as collaborative.

A predominant interaction style, the style used most frequently, was derived from a frequency count of the individual interaction styles. In the case of ties, the nurse's predominant interaction style was determined by which interaction style category had the greatest frequency of behavioral descriptors when summed across interactions. The nurse who had sufficient opportunity to interact with physicians and did not have eight interactions recorded after four observation periods was categorized as having an avoidant predominant interaction style.

#### Reliability of Interaction Coding

A second rater was given background materials and coding definitions to read. The coding system was explained, and the coding of a sample interaction was demonstrated. The second rater coded 20 interactions during two training sessions, and discrepancies were discussed. Following the training, the second rater then coded 20 interactions from transcripts. Agreement between the two raters on identification of the same behavioral units was 96 percent, and coding of the behavioral units into behavioral descriptors had 82 percent agreement.

#### Coding of Patient Care Interventions

The Record of Patient Care Interventions was coded to reflect events that followed an interaction. This record contained six categories: Medication begun, altered, deleted; Treatment begun, altered, deleted; Referral to other health professional; Medical diagnostic test ordered; Patient given information about own care; and Other. A decision usually could be made within thirty minutes of the interaction. If no alterations in patient care interventions

(PCI) took place, this fact was recorded.

#### FINDINGS AND INTERPRETATIONS

A decision analysis, in which 239 interactions and the PCI following those interactions became the focus of analysis, was undertaken. Figure 2 illustrates the decision points identified for this procedure. Also included in the figure are the table numbers provided in this report and the number of interactions at each decision point.

\*\*\*\*\*  
Place Figure 2 About Here  
\*\*\*\*\*

All 38 nurses were observed interacting with physicians at least once. A total of 239 interactions were recorded; 222 were from 29 nurses. All interaction styles were used; however, 90 percent of the interaction styles were collaborative (55%) and accommodative (35%).

In approximately half (49%) of their interactions with physicians, the nurses made no suggestions for patient care. Table I summarizes the interaction styles used by diploma and BSN nurses in the no-suggestion interactions. The majority (67%) of the interactions by both groups were in a collaborative style.

\*\*\*\*\*  
Place Table I About Here  
\*\*\*\*\*

Table II provides interaction style frequencies for those interactions in which the nurses made suggestions for patient care. The pattern of interaction styles differs by nurse education. The difference is highlighted when the patterns of interaction styles of both educational groups in Tables I and II are compared. When PCI were suggested, both groups used an accommodative style more than in no-suggestion interactions. The use of accommodation is more pronounced (72%) for diploma graduates, however. All cases of avoidance were in no-suggestion interactions.

\*\*\*\*\*

Place Table II About Here  
\*\*\*\*\*

The final sorting of the PCI data reflected the amount of influence the nurses' suggestions had on the actual PCI that were carried out (Table III). Of the 101 interventions that occurred after the nurses made suggestions, 91 were the same type of intervention as was suggested by the nurse.

\*\*\*\*\*  
Place Table III About Here  
\*\*\*\*\*

Calculation of percentages based on cell frequencies from different decision points in this analysis yielded the following information:

Those interactions in which the nurses suggested a PCI (N=122) were followed by an intervention of the same type (N=91) as proposed by the nurses 76 percent of the time.

For diploma graduates, PCI that were suggested in a collaborative style (9) were followed by an intervention of the same type (6) as proposed 67 percent (6/9) of the time. PCI that were suggested in an accommodative style (26) were followed by an intervention of the same type (21) as proposed 81 percent (21/26) of the time.

For BSN graduates, 84 percent (36/43) of the collaborative interactions were followed by the proposed intervention, and 63 percent (24/38) of the accommodative interactions were followed by the proposed intervention.

The effectiveness of collaborative and accommodative interaction styles in procuring desired PCI seems to be related to the education of the nurse. The 12 diploma graduates had a wide age range, from 23 to 59. Seven of these nurses were below 40 years old; only four were below 30. Diploma schools have a tradition of training their students to use accommodative strategies. When these are used in nursing practice, their effectiveness (81%) substantiates their use. The age of the diploma graduates may be an additional factor in the

success of the accommodative strategies since physicians may be more alert and responsive to indirect recommendations from older and more experienced nurses.

The 26 BSN graduates were all relatively young, ranging in age from 23 to 31. All but four were below 30. The youth of this group suggests that a clear majority were educated at a time when collegiate schools were beginning to stress the knowledge basis of nursing and the need for nursing autonomy. These nurses may have been socialized by their instructors to "talk to the doctor about..." rather than to "ask the doctor if..." They may have learned an initial approach of equality and are reinforced for it in their present nursing practice because of the high effectiveness rate (84%) for collaborative approaches.

The types of PCI the nurses suggested varied. The addition, deletion, or alteration of a medication was suggested most frequently, and it accounted for almost half (46%) of the interventions suggested by both groups. The second most frequent category (28%) for the diploma graduates, "Other", included such topics as transfer of patients to other units, special visitation privileges, and having the physician talk to family members. The second most frequently suggested PCI for BSN graduates was addition, deletion, or alteration of a treatment (20%).

As indicated in the data reported earlier, the BSN graduates presented the majority (56%) of their suggestions for PCI using a collaborative style. However, a collaborative style was not used for all categories of PCI. Suggestions concerning medications (22%) and diagnostic tests (6%) were made more frequently in an accommodative style. Although the difference between the accommodative and collaborative frequencies for medication suggestions is slight (22% to 20%), the large number of accommodative interactions is in contrast to those in other PCI categories. The higher level of accommodation in these

categories is probably because decisions about medications and diagnostic tests are commonly accepted as the physician's prerogative.

\*\*\*\*\*  
Place Table IV About Here  
\*\*\*\*\*

The interaction style used most frequently by each nurse was designated as that nurse's predominant interaction style. Table IV displays the frequencies and percentages for each of the predominant interaction styles by diploma and BSN education. A Chi-square test to analyze for differences in the three predominant interaction styles for both types of graduates was not significant. A one-way Chi-square with a hypothesis of equal expected frequencies for the three predominant styles of the BSN graduates was significant at the .05 level. In addition, a significant Chi-square value ( $p < .05$ ) was found for the difference between the collaborative and accommodative predominant interaction style categories. Yates' correction for continuity (Ferguson, 1959) was applied in the second comparison.

Although these findings suggest that BSN graduates are more likely to use collaborative approaches, they do not provide statistical support for concluding that the diploma and BSN graduates have different predominant interaction styles. A larger sample, matched for age, with more diploma graduates would have provided better statistical evidence of the relation between education and predominant interaction style.

#### CONCLUSIONS AND IMPLICATIONS

The distinction Clark and Lenburg (1980) make between rule oriented and knowledge oriented practitioners is relevant here. Rule oriented nurses follow rules, traditions, and customs, and do what physicians say to do. Knowledge oriented nurses use knowledge as the basis for their actions, and apply scientific reasoning and experience to decisions about patient care. The

collaborative and accommodative strategies were shown to be equally effective in procuring PCI in this study. The difference between them lies in the basis for their choice. Nursing is moving toward the use of knowledge as a basis for decisions and actions rather than rules, and the collaborative strategies of the BSN graduates in this study may be evidence of this trend.

Several findings of this study provide evidence of ambient social pressure, which is the result of norms, standards, and value systems of reference groups (Thomas, 1976). No nurses used a competitive predominant interaction style, and a relatively large number were categorized as avoidant because they seldom interacted with physicians. Also, more nurses were avoidant than accommodative. The absence of competitive predominant interaction styles is not surprising since these nurses were expected to work cooperatively in a bureaucratic organization. However, the large number of avoidant nurses was unexpected.

With the recent trend toward nursing autonomy, the nurses may have been more aware of and discontent with accommodative strategies. When a collaborative style is uncomfortable for a nurse, avoidance can be a way to keep from being accommodating and subservient to physicians. The 81 and 84 percent effectiveness rates for suggested PCI indicate that nurses may tend to ask physicians for things they think they will have a good chance of getting. The greater use of a collaborative style in those interactions in which PCI were not suggested supports this view. An air of equality is easier to achieve when the nurses do not place themselves in the position of being overruled by physicians. Rosse and Rosse (1981) suggest that nurses prevent themselves from suffering role conflict by setting "their role aspirations at a level just lower than the ceiling imposed by the physicians with whom they must interact ( p. 401)."

The large number of nurses who simply avoided interacting with physicians

has important implications. Avoidance by these nurses may be a symptom of their own inner conflict about interacting with physicians. These nurses may no longer be willing to accommodate to physicians but may be unable to collaborate. The consequences for patient care are profound. A nurse who avoids physicians cannot bring changes in a patient's condition to a physician's attention nor can the physician tell the nurse about the patient's medical treatment plan.

#### RECOMMENDATIONS

This study should be repeated in other settings since the subjects for this sample were limited to one hospital. The difference between the interaction styles of the diploma and BSN graduates deserves further investigation to determine whether it is reflective of different orientations toward interacting with physicians.

A more precise look at the nurses' perceptions of the functionality of their interaction styles is needed. PCI are certainly one measure of the utility of interaction style, and more refined methods of measuring their relationship to interaction style is needed. Effective and ineffective interaction strategies should be identified and described.

More information is needed about how nurses predict physicians' responses to their suggestions for PCI. When a nurse can reasonably predict a physician's response, the choice of which style to use would seem to be based on that knowledge. In some situations, however, a nurse has little prior knowledge of a particular physician and can make few predictions. The ability of the nurse to choose an effective strategy even when the physician is an unknown quantity can be vital in urgent situations.

Also important to consider is whether the nurses set limits on what they suggest. Do the nurses' perceptions of their chances of getting the PCI they suggest affect not only how the suggestions are made but also what are

suggested? The majority of the PCI suggested could be usual or "routine" for the patients' conditions.

Investigation of the areas identified is essential. Wandelt and associates (1980) identified positive professional interactions with physicians as one employment condition important to employed and unemployed registered nurses in Texas. This finding is repeated in a replication study conducted in Massachusetts ("New Study...", 1983). When more information is gained about nurses' interactions with physicians, methods of making those interactions more productive and satisfying for the nurses can be developed.

The attitude and approach of collaboration should be taught in schools of nursing and in continuing education programs for nurses. Since collaborative approaches were as effective as accommodative approaches when PCI were suggested, this position is justified. The movement of nurses toward a knowledge-based professional practice warrants deliberate education in these necessary interactional strategies.

###

#### COMPETITIVE DESCRIPTORS

Quotes facts/authorities

Defends position

States position

States feelings

Uses evaluative/dogmatic phrases

#### ACCOMMODATIVE DESCRIPTORS

Uses humor

Gives support to other

States position through questions

Changes to neutral topic

Uses disclaimers/qualifiers

Uses veiled recommendations

#### COLLABORATIVE DESCRIPTORS

Requests feelings

Requests information/rationale

States differences

Describes perception of other's position

Identifies areas of agreement

Provides information/rationale

States position

States feelings

#### AVOIDANT DESCRIPTORS

Does not respond to other's statement of problem/situation

Does not state own knowledge of problem/situation

Complies with other

Gives neutral responses to questions

Figure 1. Interaction Coding Guide

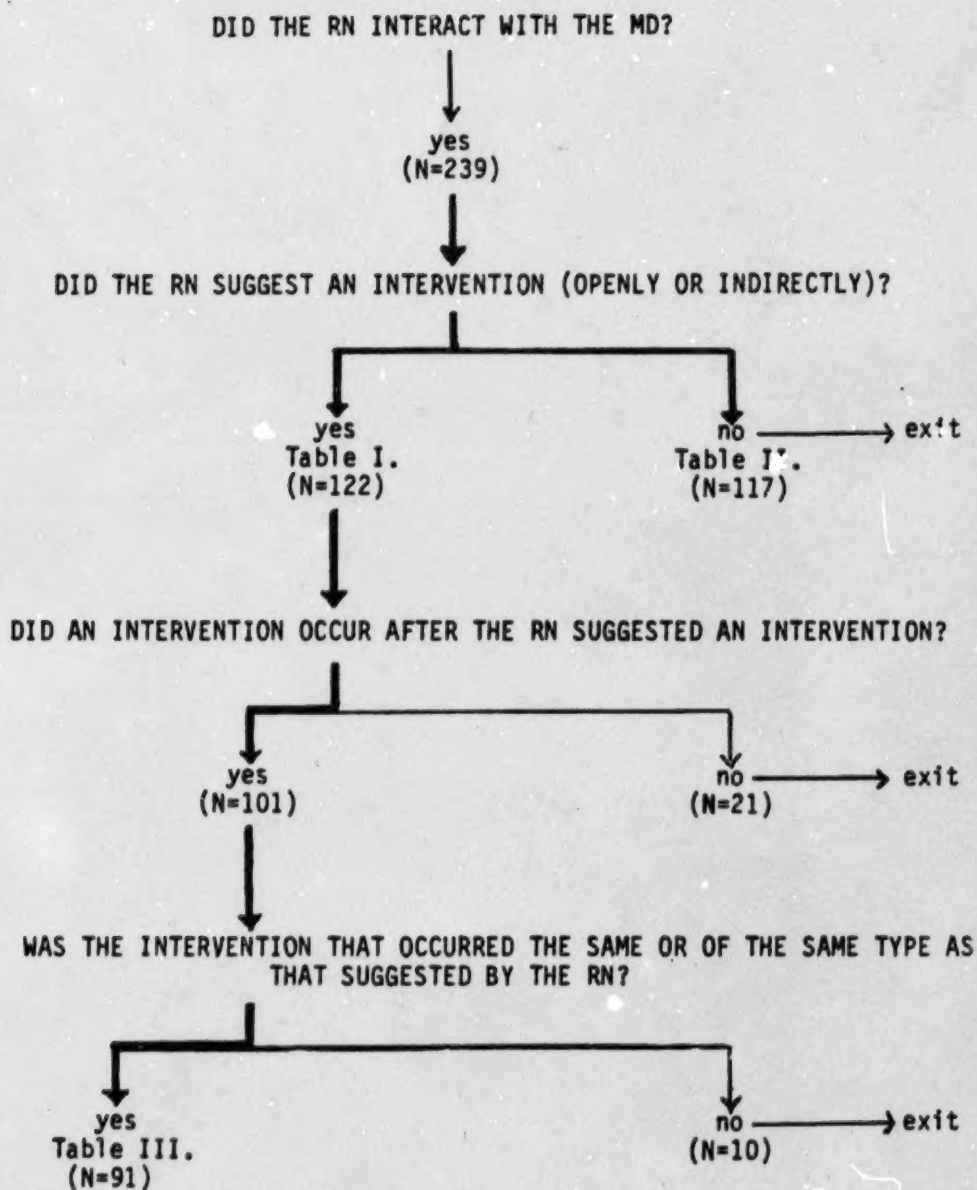


Figure 2. Decision Points For Analysis Of 239 Interaction Styles And Patient Care Interventions

TABLE I.

COMPARISON BY EDUCATION OF FREQUENCY AND PERCENT OF FIVE INTERACTION STYLES  
 USED BY 38\* REGISTERED NURSES DURING 117 INTERACTIONS IN WHICH  
 PATIENT CARE INTERVENTIONS WERE NOT SUGGESTED

| Interaction   | Educational Level |         |     |
|---------------|-------------------|---------|-----|
| Style         |                   | Diploma | BSN |
|               | f                 | 21      | 58  |
| Collaborative | %                 | 62      | 70  |
|               | f                 | 8       | 13  |
| Accommodative | %                 | 24      | 16  |
|               | f                 | 4       | 9   |
| Avoidant      | %                 | 12      | 11  |
|               | f                 | 1       | 2   |
| Competitive   | %                 | 3       | 2   |
|               | f                 | 0       | 1   |
| Compromise    | %                 | 0       | 1   |
|               | f                 | 34      | 83  |
| Total         | %                 | 100     | 100 |

\*Includes 12 diploma and 26 BSN graduates.

TABLE II.

COMPARISON BY EDUCATION OF FREQUENCY AND PERCENT OF FIVE INTERACTION STYLES  
 USED BY 36\* REGISTERED NURSES DURING 122 INTERACTIONS IN WHICH  
 PATIENT CARE INTERVENTIONS WERE SUGGESTED

| Interaction<br>Style | Educational Level |     |
|----------------------|-------------------|-----|
|                      | Diploma           | BSN |
| Collaborative        | f                 | 9   |
|                      | %                 | 25  |
| Accommodative        | f                 | 26  |
|                      | %                 | 72  |
| Avoidant             | f                 | 0   |
|                      | %                 | 0   |
| Competitive          | f                 | 0   |
|                      | %                 | 0   |
| Compromise           | f                 | 1   |
|                      | %                 | 3   |
| Total                | f                 | 36  |
|                      | %                 | 100 |

\*Includes 11 diploma and 25 BSN graduates; one diploma and one BSN graduate did not suggest any patient care interventions.

TABLE III.

COMPARISON BY EDUCATION OF FREQUENCY AND PERCENT OF FIVE INTERACTION STYLES  
 USED BY 36\* REGISTERED NURSES DURING 91 INTERACTIONS AFTER WHICH  
 SUGGESTED PATIENT CARE INTERVENTIONS WERE IMPLEMENTED

| Interaction<br>Style | Educational Level |     |
|----------------------|-------------------|-----|
|                      | Diploma           | BSN |
| Collaborative        | f                 | 6   |
|                      | %                 | 36  |
| Accommodative        | f                 | 21  |
|                      | %                 | 24  |
| Avoidant             | f                 | 0   |
|                      | %                 | 0   |
| Competitive          | f                 | 0   |
|                      | %                 | 0   |
| Compromise           | f                 | 1   |
|                      | %                 | 3   |
| Total                | f                 | 28  |
|                      | %                 | 63  |

\*Includes 11 diploma and 25 BSN graduates; one diploma and one BSN graduate did not suggest any patient care interventions.

TABLE IV.

COMPARISON BY EDUCATION OF FREQUENCY AND PERCENT OF PREDOMINANT INTERACTION  
STYLES OF 38\* REGISTERED NURSES BY BASIC EDUCATIONAL LEVEL

| Predominant<br>Interaction Style | Educational Level |     |
|----------------------------------|-------------------|-----|
|                                  | Diploma           | BSN |
|                                  | f                 | 3   |
|                                  | 14                |     |
| Collaborative                    | %                 | 25  |
|                                  | 54                |     |
|                                  | f                 | 4   |
|                                  | 4                 |     |
| Accommodating                    | %                 | 33  |
|                                  | 15                |     |
|                                  | f                 | 5   |
|                                  | 8                 |     |
| Avoidant                         | %                 | 42  |
|                                  | 31                |     |
|                                  | f                 | 12  |
|                                  | 26                |     |
| Total                            | %                 | 100 |
|                                  | 100               |     |

$X^2$  for both educational categories = 3.069 with 2 d.f.  $p = n.s.$

$X^2$  for all BSN categories = 5.846 with 2 d.f.  $p = <.05$

## LIST OF REFERENCES

- Bates, B., & Chamberlin, R.W. Physician leadership as perceived by nurses. Nursing Research, 1970, 19, 534-539.
- Blake, R., & Mouton, J.S. The managerial grid. Houston: Gulf Publishing, 1964.
- The new managerial grid. Houston: Gulf Publishing, 1978.
- Clark, N.M., & Lenburg, C.B. Knowledge-informed behavior and the nursing culture: A preliminary study. Nursing Research, 1980, 29, 244-249.
- Duff, R.S., & Hollingshead, A.B. Sickness and society. New York: Harper & Row, 1968.
- Ferguson, G.A. Statistical analysis in psychology and education. New York: McGraw-Hill, 1959.
- Hall, J. Conflict management survey. The Woodlands, Texas: Teleometrics International, 1969.
- Jamieson, D.W., & Thomas, K.W. Power and conflict in the student-teacher relationship. Journal of Applied and Behavioral Science, 1974, 10, 321-336.
- Lawrence, P.R., & Lorsch, J.W. Differentiation and integration in complex organizations. Administrative Science Quarterly, 1967, 12, 1-47.
- Levin, P., & Berne, E. Games nurses play. American Journal of Nursing, 1972, 72, 483-487.
- New study reports why Massachusetts nurses drop out. American Journal of Nursing, 1983, 83, pp. 9, 136, 138, 144.
- Rosse, J.G., & Rosse, P.H. Role conflict and ambiguity: An empirical investigation of nursing personnel. Evaluation and the Health Professions, 1981, 4, 385-405.
- Ruble, T.L., & Thomas, K.W. Support for a two-dimensional model of conflict behavior. Organizational Behavior and Human Performance, 1976, 16, 143-155.
- Rushing, W.A. Social influence and the social-psychological function of deference in J.K. Skipper, Jr. & R.C. Leonard (eds) Social interaction and patient care. Philadelphia: J.B. Lippincott, 1965, 366-376.
- Stein, L.I. Male and female: The doctor-nurse game. Archives of General Psychiatry, 1967, 16, 699-703.
- Taylor, C. In horizontal orbit. New York: Holt, Rinehart & Winston, 1970.
- Thomas, K. Conflict and conflict management in M. Dunette (ed) Handbook of industrial and organizational psychology. Chicago: Rand McNally, 1976, 889-935.

LIST OF REFERENCES (CONTD)

Wandelt, M.A., Hales, G.D., Merwin, C.M., Olsson, N.G., Pierce, P.M., & Widdowson, R.R. Conditions associated with registered nurse employment in Texas. Austin: Center for Research, The University of Texas at Austin School of Nursing, 1980.